U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 01May2001

Case No.: 2000-BLA-0433

In the Matter of:

CHESTER W. RAY, Deceased,
by MARY E. RAY, Widow,

and

MARY E. RAY, Widow of
CHESTER W. RAY,
Claimants

v.

PEABODY COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Joseph H. Kelley, Esq.
For the Claimant

Philip J. Reverman, Jr., Esq.
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from claims filed by Chester W. Ray and Mary E. Ray for benefits under the Black Lung Benefits Act,

[1] The Director, Office of Workers' Compensation Programs, was not represented at the hearing.

30 U.S.C. §§ 901, *et seq.*, as amended (Act). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP). The regulations issued under the Act are located in Title 20 of the Code of Federal Regulations, and regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

Benefits under the Act are awarded to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. Survivors of persons who were totally disabled at their times of death or whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment and is commonly known as black lung disease.

A formal hearing was held in Madisonville, Kentucky on August 30, 2000. Each of the parties was afforded full opportunity to present evidence and argument at the hearing as provided in the Act and the regulations thereunder. The findings and conclusions that follow are based on my observation of the demeanor and appearance of the witness who testified at the hearing and a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. PROCEDURAL HISTORY

The Miner, Chester W. Ray, filed a claim for benefits under the Act on February 16, 1989 (DX 41, p. 145).[2] OWCP, on August 11, 1989, denied the claim (DX 41, p. 85). The Miner requested a formal hearing by letter dated August 13, 1989 (DX 41, p. 84). No hearing was held and on November 9, 1989, OWCP issued a letter again denying the claim (DX 41, p. 76). The Miner did not appeal. On July 9, 1998, Mr. Ray filed a second application for benefits (DX 1). OWCP denied the claim on November 10, 1998 (DX 1). The Miner died on November 22, 1998 (DX 6). By letter dated December 21, 1998, the Miner's Widow, Mary E. Ray, appealed the denial on behalf of her husband (DX 21).

Mrs. Ray, the Claimant herein, filed a claim for survivor's benefits on December 18, 1998 (DX 2). OWCP, on March 29, 1999,

[2] In this Decision and Order, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, and "Tr." refers to the transcript of the August 30, 2000 hearing.

denied both the Miner's and the Widow's claims (DX 18). On April 6, 1999, the Claimant requested that the claims be consolidated and requested a formal hearing before the Office of Administrative Law Judges (DX 22). The District Director, on October 26, 1999, issued a Proposed Decision and Order Memorandum of Conference denying both claims (DX 38). The Claimant appealed and the case was forwarded to the Office of Administrative Law Judges on February 9, 2000 (DX 43). A hearing was held in Madisonville, Kentucky on August 30, 2000.

II. ISSUES[3]

The specific issues presented for resolution are as follows:

1. Whether the Miner had pneumoconiosis as defined in the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner was totally disabled;

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[3] At the hearing, the parties stipulated to thirty-seven years of coal mine employment (Tr. 9–10). Timeliness and whether the evidence establishes a change in conditions and/or that a mistake in fact was made in the prior denial per 20 C.F.R. § 725.310 were withdrawn as Issues (Tr. 9, 12). In addition, a question was raised concerning whether the Miner's current claim constitutes an original or duplicate claim.

The Miner initially filed a claim for benefits on February 16, 1989. Following OWCP's August 11, 1989 denial, Mr. Ray requested a formal hearing. No hearing was held and OWCP again denied the claim on November 9, 1989. Section 725.450 provides that "[a]ny party to a claim shall have a right to a hearing concerning any contested issue of fact or law unresolved by the deputy commissioner." Section 725.451 states that "[i]f a hearing is requested, or if a deputy commissioner determines that a hearing is necessary to the resolution of any issue, the claim shall be referred to the Chief Administrative Law Judge for a hearing under § 725.421." As a hearing was requested but not provided in the Miner's February 1989 claim, such claim remains viable. Accordingly, I find that the Miner's claim for benefits constitutes an original claim and not a duplicate claim. Therefore, whether the evidence establishes a material change in conditions per § 725.309 is not an issue to be decided.

4. Whether the Miner’s disability was due to pneumoconiosis;

5. Whether the Miner’s death was due to pneumoconiosis; and,

6. Whether *res judicata* applies to the Miner’s and the Widow’s claims.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The Miner was born on March 19, 1926 and died on November 22, 1998 at the age of seventy-two (DX 6). He married Mary E. (Brown) Ray on February 7, 1947 (DX 41, p. 112). She has not remarried since his death and is the surviving spouse of the Miner (Tr. 14).

Most physicians of record noted that Mr. Ray had a smoking history of one pack per day for over forty years. Several physicians noted that he began smoking at age eighteen [1944] and continued to smoke until his death in 1998. Based on the histories noted by the physicians of record, I find that the Miner had a smoking history of fifty-four pack years.

Length of Coal Mine Employment/Responsible Operator

The parties stipulated to thirty-seven years of coal mine employment. As this is supported by the evidence, I find that the Miner had thirty-seven years of coal mine employment.

Peabody Coal Company has been designated as the Responsible Operator with Peabody Investments, Inc., as its Carrier. This designation is undisputed and is supported by the evidence. I find that Peabody Coal Company is the proper Responsible Operator.

IV. MEDICAL EVIDENCE

In addition to the evidence listed below, the record contains numerous medical reports pertaining to the Miner's colon cancer. Such records are not pertinent to the issues in this case and will not be discussed further in this Decision and Order.

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standards
1.	07/20/98	DX 15	Sargent B reader[4]	No pneumo.	Good

[4] A B reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination

	Date	Exhibit	Doctor	Reading	Standards
			Board cert.[5]		
2.	07/20/98	DX 8	Traughber	No pneumo.	Good
3.	06/01/98	DX 14	King	No active disease	Not stated
4.	05/30/98	DX 14	King	No acute cardio-pulmonary disease	Not stated
5.	01/03/91	DX 41	Lane B reader	1/0 q,p	Good
6.	12/14/90	DX 41	Gallo	COPD; Category 0	Not stated
7.	11/19/90	DX 10	Anderson	1/1 p	Good
8.	09/13/89	DX 16	Sargent B reader Board cert.	0/1 s,s	Fair
9.	09/13/89	DX 17	Barrett B reader Board cert.	No pneumo.	Good

conducted by or on behalf of the Department of Health and Human Services.

[5] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202(a)(ii)(C).

10.	09/13/89	DX 10	Wright	2/1	Not stated
11.	03/28/89	DX 41	O'Bryan B reader	1/0 q,q	Good
12.	03/28/89	DX 41	Sargent B reader Board cert.	No pneumo.	Fair
13.	03/28/89	DX 41	Gordonson B reader Board cert.	0/1 q,t	Fair

Pulmonary Function Studies[6]

	Date	Exhibit	Doctor	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
1.	09/16/98	DX 11	Gallo	72/68"	.89	2.57	60	35%	Tracings included
	Comment:	Dr. Gallo noted that the values may have been affected by the Miner's weakness from his colon cancer. The test was ended due to weakness (DX 11).							
	Validation:	Dr. N.K. Burki, who is Board certified in Internal Medicine and Pulmonology, found this study to be invalid based on Dr. Gallo's comments (DX 11).							
2.	07/20/98	DX 8	Traughber	72/69"	2.01	3.47	38	58%	Tracings included
3.	01/03/91	DX 41	Lane	64/ 68¾"	2.29	4.12	92.7	56%	Good effort; tracings included
4.	12/14/90	DX 41	Gallo	64/69"	2.32	4.33	86	54%	Good effort; tracings included
5.	11/19/90	DX 10	Anderson	64/--	2.31	4.07	--	57%	No tracings
6.	09/07/90	DX 10	Houser	64/68"	2.10	3.73	80.5	56%	No tracings
		Post-bronchodilator			2.60	4.05	97.1	64%	
	Comment:	Dr. Houser commented that low FEV.5 values suggest poor initial effort (DX 10).							
7.	08/24/90	DX 10	Wright	64/69"	1.97	3.26	77.6	60%	No tracings
		Post-bronchodilator			2.43	3.85	86.3	63%	
8.	12/22/89	DX 41	Culbertson	63/69"	2.61	3.70	96	71%	Tracings
		Post-bronchodilator			2.85	3.91	97	73%	included
9.	03/28/89	DX 41	O'Bryan	63/	2.66	4.59	100	58%	Good coop. &

[6] Because the physicians conducting pulmonary function studies noted varying heights, I must make a finding on the Miner's height. *See Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983). Based on the height most frequently noted, I find that the Miner was sixty-nine inches tall.

	67½″	comp.; tracings included

Arterial Blood Gas Studies

	Date	Exhibit	pCO_2	pO_2
1.	07/20/98	DX 8	36	100
2.	07/09/98	DX 14	38	90
3.	12/14/90	DX 41	32	92
4.	11/19/90	DX 10	36	73
5.	09/16/90	DX 9	36	81
6.	03/28/89	DX 41	31.9	73.6

Death Certificate

The Certificate of Death, signed by Dr. Henry R. Bell, Jr., states the date of death as November 22, 1998 and the immediate cause of death as "metastatic carcinoma colon" with an onset of nine months. Dr. Bell listed "black lung" and COPD as other significant conditions contributing to death but not resulting in the underlying cause of death (DX 6).

Narrative Medical Evidence

1. Dr. Ben V. Branscomb, a B reader and Board-certified Internist, issued a consultative report dated May 3, 2000 based on the medical evidence of record. He concluded that: (1) there is no evidence Mr. Ray acquired CWP or any other disease caused or aggravated by coal dust; (2) there is a reasonable possibility that the Miner suffered a mild nondisabling obstructive impairment caused by smoking and unrelated to coal dust exposure; (3) Mr. Ray's death was due to colon cancer and not by any pulmonary disease; (4) the evidence does not show any significant deterioration in the Miner's pulmonary status between 1989 and the time of his death; (5) assuming the Miner did suffer from pneumoconiosis, it did not cause or contribute to his death or his chronic asthmatic bronchitis, and he was not totally disabled from a pulmonary standpoint at the time of his death (EX 5).

2. Dr. Gregory J. Fino, who is a B reader and is Board certified in Internal Medicine and Pulmonology, issued a consultative report dated April 7, 2000 based on the available medical records, including the death certificate. He opined that the Miner did not suffer from pneumoconiosis based on a

majority of negative x-ray interpretations, the absence of interstitial abnormality on spirometric testing, reversibility on bronchodilation, and normal blood gas testing. Dr. Fino also concluded: (1) the Miner did not suffer from any occupationally acquired pulmonary condition; (2) he had a nondisabling respiratory impairment due to cigarette smoking; (3) coal dust inhalation did not contribute to or hasten the Miner's death; and, (4) Mr. Ray would have died as and when he did had he never stepped foot in the mines. Dr. Fino discussed several articles published by the American College of Physicians, the American Thoracic Society, and the American Medical Association, among others, in support for his position (EX 4).

3. Dr. P. Raphael Caffrey, who is Board certified in Anatomical and Clinical Pathology, issued a consultative report dated March 14, 2000 based on his review of numerous medical records, including the death certificate. Dr. Caffrey opined that the Miner "most likely" suffered from a mild degree of simple coal workers' pneumoconiosis, but he was not disabled by that condition and it did not cause or contribute to his death. Mr. Ray had COPD, namely emphysema and bronchitis. Dr. Caffrey attributed the emphysema to a significant smoking history. He concluded that the Miner died from metastatic colon cancer, unrelated to coal dust exposure (EX 3).

4. Dr. Echols A. Hansbarger, Jr., who is Board certified in Anatomic and Clinical Pathology and Forensic Medicine, issued a consultative report dated March 7, 2000 based on numerous medical records, including the death certificate. Dr. Hansbarger concluded: (1) Mr. Ray died as a direct result of metastatic colon cancer, a disease of the general population; (2) the Miner suffered from COPD which was undoubtedly due to smoking and was unrelated to coal dust exposure; (3) there is no evidence of pneumoconiosis in the record of any variety; (4) the Miner's death was not hastened in any way by his coal mine employment; and, (5) Dr. Bell's finding that pneumoconiosis contributed to the Miner's death is not supported by the record (EX 2).

5. a. The record contains numerous medical reports by various physicians from Jennie Stuart Medical Center dated between May 29, 1998 and October 10, 1998. These reports pertain primarily to the Miner's colon cancer, however, some include a diagnosis of COPD. Dr. Henry R. Bell, Jr., diagnosed COPD on several occasions but did not give an opinion as to the cause of the impairment (DX 13). He noted in an October 8, 1998 Admission Report that the Miner suffered from COPD, that he "worked in the coal mines for a long period of time," and that

he "does not smoke" (DX 14). Dr. Bell also noted that the Miner "recently apparently was told that he did not have black lung. This threw him into a turmoil and apparently he started having increasing pain." By letter dated February 12, 1999, Dr. Bell stated that he first saw the Miner in May 1998 with complaints of shortness of breath, pain on ambulation and tenderness in the epigastric area. He was found to have colon cancer and "is also known to have black lung pneumoconiosis" (DX 14). Dr. Bell treated the Miner for COPD. He concluded that "Mr. Ray died of colon cancer which was hastened by his pneumoconiosis."

b. Dr. Bell testified by deposition on September 24, 1999 (EX 1). He stated that he never diagnosed black lung. Although Dr. Bell wrote "black lung" and COPD as significant conditions contributing to death but not resulting in the underlying cause of death on the death certificate, he stated that his opinion regarding black lung was based solely on the history given to him by the Miner. He based his finding of COPD on symptoms and physical examination. As to why he believed black lung and COPD contributed to the Miner's death, Dr. Bell stated that he felt such conditions "added to the load that he carried with the cancer of the colon." He opined that the Miner did not have the physical ability to perform his usual coal mine work and that COPD was a factor in such impairment. Dr. Bell did not know the Miner's smoking history. He opined that the degree to which smoking and coal dust exposure contributed to the Miner's impairment could not be separated.

c. Dr. Marshall Vanmeter signed the Discharge Summary regarding the Miner's May 29, 1998 to June 6, 1998 hospitalization. His final diagnoses included COPD but he did not give an opinion as to the cause (DX 14).

d. Dr. Kenneth Cloern saw the Miner on July 9, 1998 for shortness of breath. He performed an arterial blood gas study and diagnosed subjective dyspnea. Dr. Cloern suspected "that this may be a high component of anxiety" (DX 14).

6. a. Dr. Thomas A. Gallo, who is Board certified in Internal Medicine and Pulmonology, examined the Miner on September 16, 1998. He performed a pulmonary function study (severe obstruction; mild restriction; test ended due to weakness) and an arterial blood gas study (normal) and interpreted an x-ray (category 0). He noted that the Miner had colon cancer and stated that the value of the pulmonary function study was affected by the Miner's generalized weakness. Dr. Gallo opined that the Miner showed slight hyperinflation on x-ray consistent with a history of COPD and that the x-ray was

unchanged from his prior evaluation of the Miner in December 1990 (DX 9).

b. Dr. Gallo first examined the Miner on December 14, 1990. Dr. Gallo noted the Miner's symptoms (shortness of breath, cough, sputum, wheezing), as well as his occupational (forty years strip mining), smoking (one pack per day for forty-six years) and medical (eye operation) histories. He physically examined Mr. Ray, performed pulmonary function (moderate obstruction) and arterial blood gas (normal) testing, and interpreted an x-ray (no pneumoconiosis). Dr. Gallo diagnosed chronic obstructive pulmonary disease, bronchitis, and emphysema and stated that he does not believe the Miner suffered from pneumoconiosis (DX 9).

7. Dr. Sam H. Traughber examined Mr. Ray on July 20, 1998. He reviewed the Miner's symptoms (sputum, wheezing, dyspnea, cough, ankle edema, paroxysmal nocturnal dyspnea) and his occupational (forty-two years mining), smoking (one-half pack per day for forty years and continues to smoke) and medical (wheezing, colon cancer) histories. Dr. Traughber performed a physical examination, pulmonary function (moderate obstruction) and arterial blood gas (normal) tests, and interpreted an x-ray (consistent with old granulomatous disease). He diagnosed "probable obstructive airway disease" and old granulomatous disease. He stated the etiology of the airway disease as "probably emphysema due to cigarette smoking" and attributed the granulomatous disease "probably" to histoplasmosis. Dr. Traughber found a moderate obstructive impairment and concluded that the Miner lacked the respiratory capacity to perform his usual coal mine work. He could not apportion the extent of the impairment which was due to each of the above-mentioned diagnoses but stated that "cigarette smoking is probably the main etiology of his obstructive ventilatory deficit." He noted that the Miner's colon cancer did not contribute to the respiratory impairment (DX 8).

8. a. Dr. Emery Lane, who is a B reader and a Board-certified Internist, examined Mr. Ray on January 3, 1991. Dr. Lane reviewed the Miner's symptoms (shortness of breath, cough, sputum), and his occupational (forty-two years surface mining), smoking (one pack per day for forty-two years), and medical (eye surgery, hearing difficulty) histories, and performed a physical examination, a pulmonary function study, an arterial blood gas study, and interpreted an x-ray (1/0 q,p) and an EKG (nonspecific abnormalities). Dr. Lane found evidence of an occupational lung disease on x-ray and opined that the Miner

retained the respiratory capacity to perform his usual work (DX 41, p. 60).

b. Dr. Lane was deposed on February 5, 1991. He opined that the Miner suffered from COPD based on smoking history and pulmonary function testing which showed a mild obstructive defect. Dr. Lane said that the Miner did not have a restrictive defect and that the obstructive defect was due primarily to smoking and not to coal dust exposure. He said, however, that it is possible that coal dust exposure played a "small" role in the obstructive impairment (DX 41, p. 29).

9. Dr. William H. Anderson examined the Miner on November 19, 1990. He noted the Miner's symptoms (shortness of breath, cough, sputum), and his occupational (forty-two years surface mining), smoking (one pack per day since age eighteen and still smokes), and medical (difficulty hearing) histories. Dr. Anderson performed a physical examination, pulmonary function (class 2 impairment), and arterial blood gas testing, and interpreted an x-ray (1/1) and an EKG (abnormal). He diagnosed: (1) "Category 1, sufficient nodulation in comparison to standard film;" (2) Pulmonary emphysema with mild obstructive ventilatory defect. Residual volume is 166%. Thus, this is the type of emphysema related to cigarette smoking; (3) Arteriosclerotic heart disease with right bundle branch block; and, (4) Nerve deafness. Dr. Anderson opined that the Miner suffered from an occupational lung disease and retained the respiratory capacity to perform his usual coal mine work (DX 10).

10. Dr. William C. Houser examined Mr. Ray on September 7, 1990, at which time he reviewed the Miner's symptoms ("no air," dyspnea, cough, sputum, wheezing), and his occupational (forty-one to forty-two years surface mining), smoking (one pack per day for forty-six years), and medical (bronchitis) histories. Dr. Houser performed a physical examination and a pulmonary function study (moderately severe obstruction) and interpreted an x-ray (2/1). He noted 94% saturation on a pulse oximeter. Dr. Houser diagnosed: (1) coal workers' pneumoconiosis based on x-ray and length of employment; (2) COPD based on pulmonary function testing; and, (3) chronic bronchitis based on a history of cough and sputum production. He concluded that the Miner was unable to do his usual coal mine work from a pulmonary standpoint (DX 10).

11. Dr. Ballard Wright examined Mr. Ray on August 24, 1990, at which time he reviewed the Miner's symptoms (cough, shortness of breath, wheezing), and his occupational (thirty-two years

surface mining), smoking (one pack per day for over thirty years and still smokes), and medical (unremarkable) histories. Dr. Wright performed a physical examination and a pulmonary function study (severe obstruction; restrictive impairment cannot be excluded), and interpreted an x-ray dated September 13, 1989 (2/1). He diagnosed: (1) coal workers' pneumoconiosis 2/1; (2) COPD, mixed bronchitic and emphysematous types, severe, associated with smoking and inhalation of respirable dust; and, (3) "cardiac arrhythmia, no diagnosis." Dr. Wright opined that the Miner suffered from an occupationally acquired lung disease based on x-ray and was unable to perform his usual employment based on spirometric testing (DX 10).

12. Dr. William H. Culbertson examined Mr. Ray on December 22, 1989. He reviewed the Miner's symptoms (shortness of breath, cough, sputum), as well as his occupational (forty-one years strip mining), smoking (one pack per day for forty years and continues to smoke), and medical (unremarkable) histories. Dr. Culbertson performed a physical examination and a pulmonary function study (mild obstruction), and interpreted an x-ray (scattered opacities in left lobe otherwise lungs fields are hyperinflated with no other increased markings). He diagnosed mild chronic bronchitis by history and scarring of the lingula, probably related to chronic bronchitis. Dr. Culbertson found no evidence of pneumoconiosis and opined that the Miner was not totally disabled (DX 41, p. 18).

13. Dr. William O'Bryan examined the Miner on March 28, 1989, at which time he reviewed Mr. Ray's symptoms (sputum, wheezing, dyspnea, cough), and his occupational (forty years aboveground mining), smoking (one to one-and-one-half packs per day for forty-five years and still smokes), and medical (skin cancer, burn injury, eye surgery) histories, and performed a physical examination, a pulmonary function study (no impairment), an arterial blood gas study (abnormal), and interpreted an x-ray (1/0). Dr. O'Bryan diagnosed category 1 pneumoconiosis and asthmatic bronchitis. As to the etiology of the pneumoconiosis, Dr. O'Bryan wrote, "presumed due to coal dust exposure." He stated the etiology of the bronchitis as "possible allergies, possible nonspecific wheezing and bronchitic illness" and opined that "his smoking and coal dust exposure played an equal part in this process developing." Dr. O'Bryan found no ventilatory impairment. He stated that the Miner's arterial blood gas results were atypical for interstitial disease (DX 41, p. 96).

V. DISCUSSION AND APPLICABLE LAW

Miner's Claim

Because the Miner filed his claim after March 31, 1980, it must be adjudicated under the regulations at 20 C.F.R. Part 718. To be entitled to benefits, the Claimant must establish by a preponderance of the evidence that the Miner suffered from pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, and that he was totally disabled as a result of pneumoconiosis. *See* 20 C.F.R. §§ 718.202–.204.

Under § 718.202(a)(1), a claimant may prove that the miner had pneumoconiosis on the basis of x-ray evidence. The record contains thirteen interpretations of eight x-rays. Nine interpretations are negative and four are positive. Five of the negative interpretations are by physicians who are dually qualified as B readers and Board-certified Radiologists and four are by physicians who lack any special radiological qualifications. Two of the positive readings are by physicians who are B readers only and two are by physicians who possess no special radiological qualifications. Interpretations by B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *See Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); *Vance v. Eastern Associated Coal Corp.*, 8 B.L.R. 1-68 (1985). A physician who is a B reader as well as a Board-certified Radiologist may be credited over a physician who is only a B reader. *See Sheckler v. Clinchfield Coal Company*, 7 B.L.R. 1-128 (1984). Moreover, it is proper to accord greater weight to the most recent x-ray evidence of record. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984). The three most recent x-rays, taken in 1998, were interpreted as negative by all of the readers who interpreted them. The remaining x-rays of record were taken between 1989 and 1991. Based on a majority of negative interpretations by the most highly qualified readers and the more recent evidence, I find that the x-ray evidence fails to establish the existence of pneumoconiosis.

Under § 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy or autopsy results. This section is inapplicable in this case because the record does not contain biopsy or autopsy results. Additionally, § 718.202(a)(3) is not available because none of the presumptions of §§ 718.304, 718.305, and 718.306 apply to the facts of this case.

Section 718.202(a)(4) provides that a claimant may establish the existence of pneumoconiosis if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray,

finds that the Claimant suffers from pneumoconiosis as defined in § 718.201. Section 718.201 defines pneumoconiosis as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. It is within the Administrative Law Judge's discretion to determine whether a physician's conclusions are adequately supported by documentation. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46, 1-47 (1985). "An administrative law judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *King v. Consolidation Coal Co.*, 8 B.L.R. 1-262, 1-265 (1985).

Fifteen physicians gave opinions with respect to the existence of a respiratory impairment. Drs. Branscomb, Fino, Hansbarger, Gallo, and Culbertson found no evidence of pneumoconiosis. Drs. Traughber and Vanmeter diagnosed COPD but did not relate it to coal dust exposure. Dr. Cloern diagnosed subjective dyspnea but failed to relate it to the Miner's occupational exposure. Dr. Lane found evidence of an occupational lung disease but later recanted his opinion and said that the Miner's impairment was not due to coal dust exposure. Drs. Anderson, Houser, Wright, and O'Bryan diagnosed pneumoconiosis and Dr. Caffrey opined that the Miner "most likely" suffered from that condition. Dr. Bell listed "black lung" and COPD as underlying causes of death and opined that the Miner's COPD was due in part to coal dust exposure.

Drs. Branscomb, Fino, and Hansbarger reviewed numerous medical records and opined that the evidence fails to support a finding of pneumoconiosis or any occupationally acquired respiratory impairment. They found that the Miner suffered from a mild nondisabling respiratory impairment, attributable to smoking, and that such impairment failed to cause or contribute to the Miner's death, which was caused by metastatic colon cancer. Drs. Branscomb, Fino, and Hansbarger are highly qualified physicians and their opinions are well reasoned, well documented, and are supported by the evidence of record. Their opinions are entitled to substantial weight.

Dr. Gallo first examined the Miner in December 1990, at which time he diagnosed COPD, bronchitis, and emphysema. He opined that the Miner did not suffer from pneumoconiosis. His findings were based on examination, objective testing, and x-ray. Dr. Gallo most recently examined Mr. Ray in September 1998. He performed a pulmonary function study, the results of which he said were affected by the Miner's weakness due to colon cancer, and interpreted an x-ray as negative for pneumoconiosis

and consistent with COPD. He stated that his opinion of the Miner's respiratory condition since the 1990 examination was unchanged. Dr. Gallo examined the Miner twice over the course of eight years and opined on both occasions that the Miner did not suffer from pneumoconiosis. He is a highly qualified physician and his opinion is well reasoned, well documented, and supported by the evidence on which he relied. I find that it is entitled to substantial weight.

Dr. Culbertson examined Mr. Ray in December 1989, at which time he found no evidence of pneumoconiosis. Dr. Culbertson diagnosed chronic bronchitis, which he failed to relate to coal dust exposure. Dr. Culbertson's opinion is reasoned, documented, and is supported by the evidence on which he relied. I find that his opinion is entitled to substantial weight.

Dr. Traughber examined the Miner in July 1998, at which time he diagnosed "probable obstructive airway disease" and old granulomatous disease. He attributed the obstructive impairment to "probably emphysema due to cigarette smoking" and the granulomatous disease "probably" to histoplasmosis. He opined that the Miner was totally disabled from his usual employment and that smoking was "probably" the primary etiology of the ventilatory impairment. Dr. Traughber noted the Miner's colon cancer and stated that it did not contribute to his respiratory impairment. Dr. Traughber's opinion as to the existence of a respiratory impairment and its etiology is equivocal. Moreover, the objective studies upon which he relied yielded nonqualifying values. For these reasons, I find that Dr. Traughber's opinion is entitled to less weight than those of Drs. Branscomb, Fino, Hansbarger, Gallo, and Culbertson.

Dr. Lane examined the Miner on January 3, 1991, at which time he found evidence of an occupational lung disease on x-ray and opined that the Miner retained the respiratory capacity to perform his usual coal mine work. In a deposition taken on February 5, 1991, Dr. Lane opined that the Miner suffered from COPD based on smoking history and pulmonary function testing. He initially said that the obstructive impairment was due to smoking and not to coal dust exposure, but later said it was "possible" that coal dust exposure played a "small" role in the obstructive impairment. Because Dr. Lane recanted his earlier finding of an occupational lung disease with an equivocal finding that coal dust exposure may "possibly" have contributed to the Miner's obstructive impairment, I find that his opinion on this issue is entitled to less weight than those of Drs. Branscomb, Fino, Hansbarger, Gallo, and Culbertson.

Dr. Caffrey reviewed numerous medical records and issued a consultative report in March 2000. He opined that the Miner "most likely" suffered a mild degree of pneumoconiosis but was not totally disabled by that condition and it did not contribute to his death. Dr. Caffrey found that the Miner suffered from COPD, namely emphysema, and bronchitis. He attributed the emphysema to cigarette smoking. I have found the x-ray evidence to be negative for pneumoconiosis. Dr. Caffrey's opinion as to whether the Miner suffered from pneumoconiosis is somewhat equivocal. Moreover, he based his finding in part on Dr. Lane's January 3, 1991 opinion. "Dr. Emery Lane said that [the Miner] had coal workers' pneumoconiosis category 1/0, but that he was physically able, from a pulmonary standpoint, to do his usual coal mine employment. I think this is quite significant." Dr. Caffrey did not discuss Dr. Lane's February 1991 deposition testimony in which Dr. Lane recanted his earlier opinion. For these reasons, I find that Dr. Caffrey's opinion as to the presence of pneumoconiosis is entitled to less weight than the better-reasoned, better-documented, and better-supported opinions of Drs. Branscomb, Fino, Hansbarger, Gallo, and Culbertson.

Dr. Bell treated the Miner from May 1998 until October 1998. The record contains several reports by Dr. Bell and the Certificate of Death is signed by Dr. Bell. Dr. Bell diagnosed COPD on several occasions but did not relate it to coal mine employment. He noted that Mr. Ray worked in the mines for "a long period of time" and that he did not smoke. Dr. Bell, on the Certificate of Death, listed "black lung" and COPD as significant conditions contributing to death but not resulting in the underlying cause of death. In February 1999, Dr. Bell issued a letter which stated that the Miner died of colon cancer "which was hastened by his pneumoconiosis." At a deposition taken on September 24, 1999, Dr. Bell admitted that he never diagnosed pneumoconiosis and that his opinion that "black lung" contributed to the Miner's death was based solely on the history related to him by the Miner. Dr. Bell opined that the Miner was totally disabled and that COPD was a factor in such impairment. He attributed the COPD to both cigarette smoking and coal dust exposure but could not separate the extent to which each contributed to the impairment. He stated that he did not know the Miner's smoking history. As to why he believed COPD contributed to the Miner's death, he said that it "added to the load that [the Miner] carried with the cancer of the colon."

I have found the x-ray evidence to be negative for pneumoconiosis. Dr. Bell admitted that he does not know the Miner's smoking history and it is unclear from the record the

coal mine employment history on which he relied. He never diagnosed pneumoconiosis and listed "black" lung as a contributing factor of death based solely on the history given to him by the Miner. He did not perform any pulmonary function or arterial blood gas studies. Dr. Bell's opinion is unreasoned, undocumented, and is unsupported by the evidence. Although he was a treating physician, I find that Dr. Bell's opinion is entitled to little weight.

Drs. Wright, O'Bryan, Anderson, and Houser examined the Miner in 1990. All four physicians gave positive x-ray readings and diagnosed pneumoconiosis. I have found the x-ray evidence to be negative for pneumoconiosis. Moreover, Drs. Wright and Houser opined that the Miner lacked the respiratory capacity to perform his usual coal mine employment although the objective studies on which they relied yielded nonqualifying values. As to the etiology of the Miner's pneumoconiosis, Dr. O'Bryan opined that it was "presumed due to coal dust exposure." I have found such opinion to be equivocal. Although Drs. Wright, O'Bryan, Anderson, and Houser examined the Miner, I find their opinions as to the existence of pneumoconiosis to be entitled to less weight than the better-reasoned, better-documented, and better-supported opinions of Drs. Branscomb, Fino, Hansbarger, Gallo, and Culbertson.

Drs. Vanmeter and Cloern examined the Miner during his various periods of hospitalization in 1998. Dr. Vanmeter diagnosed COPD and Dr. Cloern diagnosed subjective dyspnea. Neither physician related their diagnoses to coal dust exposure.

For the reasons stated above, I place greater weight on the opinions of Drs. Branscomb, Fino, Hansbarger, Gallo, and Culbertson and find that the medical opinion evidence fails to establish the existence of pneumoconiosis.

The Claimant has failed to establish that the Miner suffered from pneumoconiosis through a preponderance of the medical evidence. Therefore, the Miner's claim must fail. *See Roberts v. Bethlehem Mines Corporation*, 8 B.L.R. 1-211, 1-214 (1985). Nevertheless, I will evaluate the record to determine whether the evidence establishes total disability.

Section 718.204(c) contains the criteria for establishing total disability:

> (c) Criteria. In the absence of contrary probative evidence, evidence which meets the standards of either

paragraphs (c)(1), (2), (3), (4) or (5) of this section shall establish a miner's total disability.

Section 718.204(c)(1) permits a finding of total disability when the evidence includes pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 test results are divided by the FVC test results.

The record contains the results of twelve pulmonary function studies, including three which were performed after the administration of a bronchodilator. Only one study produced qualifying values. The September 16, 1998 study, however, was found invalid by Dr. Burki based on the comments made by Dr. Gallo, the administering physician. Dr. Gallo noted that the test had to be ended due to the Miner's weakness and stated that the values for the study may have been affected by the Miner's weakness from his colon cancer. I find that the results of this study are entitled to less weight as Dr. Gallo's comments call the validity of the study into question. Because all other studies produced non-qualifying values, I find that the pulmonary function study evidence fails to support the existence of a totally disabling respiratory impairment.

Under § 718.204(c)(2), a claimant may establish total disability with arterial blood gas studies that result in values equal to or less than those contained in the tables. Three arterial blood gas studies were performed, all of which failed to yield qualifying results. Section 718.204(c)(3) is inapplicable because no evidence suggests cor pulmonale with right-sided congestive heart failure. Likewise, § 718.204(c)(5) is not available because it applies only to survivor's claims filed before January 1, 1982.

Under § 718.204(c)(4), a claimant may establish total disability if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that the claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful work.

Eleven physicians gave opinions as to the degree of Mr. Ray's pulmonary impairment. Drs. Branscomb, Fino, Caffrey, Lane, Anderson, Culbertson, and O'Bryan found no total

disability. Drs. Bell, Traughber, Houser, and Wright found the Miner to be totally disabled from a respiratory standpoint. I have given substantial weight to the opinions of Drs. Branscomb, Fino, and Culbertson for the reasons stated above. The opinions of Drs. Caffrey, Lane, Anderson, and O'Bryan, with respect to the total disability issue, are supported by the objective medical evidence on which they relied. Accordingly, I find that their opinions on this issue are entitled to substantial weight. Dr. Bell's opinion has been given little weight for the reasons previously stated. The opinions of Drs. Traughber, Houser, and Wright on this issue are unsupported by the objective evidence on which they relied.

Weighing the pulmonary function study, arterial blood gas study, and medical opinion evidence, I find that the Claimant has failed to establish by a preponderance of the evidence that the Miner was totally disabled from a pulmonary or respiratory standpoint.

Widow's Claim

The regulations at Part 718 provide for benefits to eligible survivors of a miner whose death was due to pneumoconiosis. *See* § 718.205(a). In a Part 718 survivor's claim, the Administrative Law Judge must make a threshold determination of the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering whether the miner's death was due to the disease under § 718.205. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-88 (1993). As stated above, the evidence fails to establish that the Miner suffered from pneumoconiosis. Thus, Mrs. Ray's claim for survivor's benefits must fail.

Assuming, *arguendo*, that pneumoconiosis was established, the Claimant would have to show that the Miner's death was due to pneumoconiosis. Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

> (1) Where competent medical evidence established that the miner's death was due to pneumoconiosis, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at § 718.304 [complicated pneumoconiosis] is applicable.

The United States Court of Appeals for the Sixth Circuit has held that "pneumoconiosis is a substantially contributing cause or factor leading to the miner's death if it serves to hasten that death in any way." *Griffith v. Director, OWCP*, 49 F.3d 184, 186 (6th Cir. 1995); *see also, Brown v. Rock Creek Mining Co., Inc.,* 996 F.2d 812, 816 (6th Cir. 1993).

Five physicians gave opinions as to the cause of Mr. Ray's death. Drs. Branscomb, Fino, Caffrey, and Hansbarger found that the Miner's death was not caused or hastened by pneumoconiosis. Dr. Bell, on the Certificate of Death, listed "black lung" and COPD as significant conditions contributing to but not resulting in the underlying cause of death. I have given substantial weight to the opinions of Drs. Branscomb, Fino, and Hansbarger, who found that the Miner's death was due to metastatic colon cancer and not to a occupationally acquired respiratory impairment. Dr. Caffrey also attributed the Miner's death to colon cancer and not to an occupationally acquired respiratory disease. His opinion on this issue is reasoned, documented, and is supported by the evidence. Dr. Bell's opinion has been given little weight because it is unreasoned, undocumented, and is unsupported by the evidence of record.

Placing greater weight on the opinions of Drs. Branscomb, Fino, Hansbarger, and Caffrey for the reasons stated above, I find that the medical opinion evidence fails to support a finding that the Miner's death was caused or hastened by pneumoconiosis.

Under § 718.304, there is an irrebuttable presumption of death due to pneumoconiosis when complicated pneumoconiosis is established. As there is no evidence of complicated pneumoconiosis, I find that the Claimant has failed to show that the Miner suffered from that condition.

Injunction Issued In National Mining Association, et al.

I have considered the injunction issued in *National Mining Association, et al. v. Elaine L. Chao, Secretary of the U.S. Department of Labor, et al.,* No. 1:00 CV 03086 (D. D.C. Feb. 9, 2001). I have determined that the revised regulations at 20 C.F.R. §§ 718.202, 718.204, and 718.205 will not affect the outcome of this case.

VI. ENTITLEMENT

Mary E. Ray, on behalf of Chester W. Ray, deceased, and as the surviving spouse of Chester W. Ray, has failed to establish entitlement to benefits under the Act. Therefore, her claims on behalf of the Miner and as the surviving spouse of the Miner must fail.

VII. ATTORNEY'S FEES

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claims of Mary E. Ray, on behalf of Chester W. Ray, deceased, and Mary E. Ray, as the surviving spouse of Chester W. Ray, are hereby DENIED.

A
ROBERT L. HILLYARD
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of the Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.